TALK AND TRANSFORMATION

RECOMMENDATIONS FOR MOVING FORWARD WITH A STRUCTURED PSYCHOTHERAPY PROGRAM IN ONTARIO

From the interdisciplinary roundtable organized by Ontario Psychiatrists

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On behalf of Ontario's psychiatrists, we are pleased to share our recent discussion paper which outlines several recommendations for improving patient care and enhancing and expanding psychotherapy in the province. Following Ontario's announcement to develop a publicly-funded psychotherapy program, the Coalition of Ontario Psychiatrists hosted a roundtable of mental health providers and leaders to share ideas and challenge the status quo. The attached paper and the recommendations within stem largely from these discussions and we believe that these findings will contribute to the discussions going forward.

Ontario's policy and funding support for improved access to psychotherapy is a historic vote of confidence for the evidence-based treatment of mental illness. As providers of care for patients with complex, severe, and chronic forms of mental illness where psychotherapy is needed or preferred, Ontario's psychiatrists are optimistic about the investment in this evidence-based method of care. At present, Ontario's psychiatrists feel strongly that the current system is not serving our patients well, in particular in providing access to psychotherapy. Just as the system must change to better serve our patients, so too must the providers, including psychiatrists. Psychiatrists need to possess both knowledge and skills in evidence-supported psychotherapies to act as medical experts, consultants, stewards of clinical service teams, shared care collaborators and trainers of future generations of mental health professionals. Improving access to psychotherapy services in Ontario will require finding new and innovative ways to link psychiatrists with other providers who can provide frontline psychotherapy services directly to more patients.

We have come a long way in improving our culture to deal more openly with mental illness and to encourage more people to seek help earlier. Unfortunately, we haven't been as successful in encouraging our medical students to choose psychiatry to serve this population. As a result, the demand for psychiatrists in Canada continues to exceed supply, and the number of residency positions allotted to psychiatry is not representative of this growing need: in 2017, psychiatry had the second-highest vacancy rate for residency of all specialties. There are a number of steps that need to be taken to improve access to mental health care in Ontario beyond increasing access to psychotherapy, and this must include training more psychiatrists to care for the acutely mentally ill.

Ontario's psychiatrists are willing to take a more active role in helping to shape our mental health system so that patients can access appropriate, high-quality care more readily.

If you wish to discuss this paper further, please contact Jessica Stepic by phone (416-433-8087) or by email (Jessica.Stepic@SantisHealth.ca).

Sincerely,

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INTRODUCTION

From veteran suicide rates to improving prison services for mentally ill offenders to calls for more services for youth and First Nations, mental health has dominated our news cycle with important messages on urgent issues. But each crisis is a peak rising from a landscape of unmet needs. Currently, some **three million Canadians are estimated to have serious depression**[1], and less than a third seek help.

When it comes to mental health, the numbers can be staggering. Mental illness is the leading cause of disability in Canada and it can cut 10 to 20 years from a person's life expectancy. It's estimated that one in five Canadians has mental health or addiction issues and that by the age of 40, fully half of us will have or have experienced some form of mental illness.[2]

There is a clear need for more and better mental health services in Ontario where 30 per cent of the population will likely experience mental illness and/or substance abuse at some point in their lives. That's why Ontario's mental health funding announcement in May 2017 included among its initiatives to develop a new, publicly-funded psychotherapy program.

In October of that same year, another announcement focused attention on the psychotherapy service expansion offering more detail in the form of three specific initiatives: the piloting of in-person individual and group psychotherapy counselling programs coordinated through Ontario's four speciality mental health hospitals; further investment in Bounce Back, a coaching program managed by Canadian Mental Health Association Ontario to teach people how to manage problems related to mild-to-moderate depression and anxiety; and, the deployment of online mental health self-management tools coordinated by the Ontario Telemedicine Network.

These programs are expected to roll out across the province over the next three years and their focus is to deliver services to Ontarians living with mild to moderate anxiety and depressive disorders. For people engaged in the delivery of mental health services in Ontario, this is viewed as a positive initial step towards building sustainable access to care. That's because a **lack of access to care is what keeps patients suffering from psychiatric disorders of mild to moderate intensity from seeking help**.

Presently, a patient with severe mental illness, one who is suicidal or who has a psychosis, for example, has a much clearer pathway to care than someone struggling with mild depression. This threshold of need is creating a system that treats mental illness only when it has become severe enough to require specialized services. Enabling patients with mild and moderate mental health conditions to more easily access psychotherapy will improve the delivery of mental health care, and improve health equity for individuals with mental illness. It provides users with the treatment they need, and frees other mental health care professionals to care for patients with more severe mental health issues. Moreover, treating people with mild and moderate mental illnesses, especially younger adults and children, may prevent them from experiencing more severe forms of mental health difficulties later.

1 https://www.mooddisorders.ca/faq-question/how-prevalent-is-depression
2 Mental Health Commission of Canada

PSYCHOTHERAPY AS PART OF THE SOLUTION

So why invest in structured psychotherapy? Because mild to moderate depression and anxiety are the most common mental health disorders, and because access to counselling and therapy services such as psychotherapy is the most commonly reported need.[3] In fact, Canadian Practice Guidelines recommend psychotherapy as the first line of treatment for the most common anxiety and depressive disorders, two groups of diagnoses that together account for almost 80 percent of all psychiatric diagnoses.

There is evidence that governments investing in the delivery of structured psychotherapy early on in an illness are seeing a return on their investment – not only by preventing an exacerbation of the problem, but also by preventing secondary effects such as problems at school, absenteeism from work, job loss and addictions. And the economic impact of anxiety and depression is well known. The Mental Health Commission of Canada estimates the health care costs and lost productivity at $51 billion per year.[4]

But there's another reason to focus here: mood disorders are highly treatable. It's estimated that 80 to 90 percent of people with major depression can be treated successfully[5], but they must have access to the right services. And how to get there is not always well understood.

Even further, there is evidence that psychotherapy works. The United Kingdom's NHS program, Improving Access to Psychological Therapies Initiative (IAPT), offers publicly funded psychotherapy through a stepped-care model for treating anxiety and depression. The 2016-17 annual report on the use of IAPT services found that there were 1,385,664 new referrals, of which 965,379 referrals entered treatment. 87.5% of those that entered treatment waited less than 6 weeks to be treated (and 98.2% waited less than 18 weeks). 49.3% of patients that finished treatment entered recovery.[6] The economic outcomes are promising, too: to offset the public cost of treatment, employment status (resulting from work absenteeism due to mental health) would have to increase by 4%; IAPT exceeded this goal, increasing employment status by 5%.[7]

3 Ontario government announcement
4 Smetanin et al. (2011). The life and economic impact of major mental illnesses in Canada: 2011-2041. Prepared for the Mental Health Commission of Canada. Toronto: RiskAnalytica.
5 American Psychiatric Association
6 http://www.digital.nhs.uk/catalogue/PUB30232
7 https://www.theglobeandmail.com/opinion/for-better-mental-health-care-in-canada-look-to-britain/article37358415/

HOW ONTARIANS LOOK FOR MENTAL HEALTH HELP

For a great number of Ontarians, their family physician is the first person they talk to about a mental health issue. Yet only some of those physicians will have a colleague, service or program to which they can confidently refer their patients for mental health treatment.

Some doctors may not even be aware of all their own community's mental health resources. And others will offer talk therapy to the best of their abilities to fill the six to 12-month wait time it may take to see a psychiatrist, who provides care across the continuum of mental illness complexity, serving patients with mild-to-moderate conditions to complex disorders requiring high-intensity care. In fact, because of the long wait times compounded by a shortage of psychiatrists, some estimates indicate that family doctors spend one-third of their time caring for those with mental health concerns.[8]

Of course, Ontarians access help for mental health issues in a number of ways. Hospital emergency departments, social workers, psychologists, nurses, employee assistance programs, religious communities, public agencies and helplines are some of the ways we find access to therapy. Despite the number of paths into mental health care, or perhaps because of it, a patient's care journey is often disjointed and its resolution far from assured. And importantly, there's a lack of access to the evidence-based best practice of structured psychotherapy.

However, the delivery of structured psychotherapy is not clearly defined. And even if a patient is fortunate enough to have access to an employee assistance program that offers psychotherapy, these can be restrictive in terms of what's included and for how long.

Often the choice amounts to waiting months for a psychiatrist appointment or paying out of pocket to see a psychologist or other therapist.

Psychotherapy is an effective treatment for anxiety and depressive disorders and if more people can access this type of modality, we can make significant gains. But what is the best way to deliver this access? How do you triage patients in a way that consistently identifies them, system-wide, as mild, moderate or severe? What are the different challenges facing this large and generally underserved constituency?

8 https://www.theglobeandmail.com/life/the-case-for-publicly-funded-therapy/article24567332/

THE CONTEXT OF THE ROUNDTABLE DISCUSSION

To answer some of these questions and develop a greater cross-disciplinary consensus on the challenges at every level of access, Ontario Psychiatrists coordinated and hosted a one-day roundtable. It was a unique gathering of mental health care providers rarely seen assembled in one space. Among the attendees were psychologists, social workers, occupational therapists, psychiatrists, medical psychotherapists, lived experience advisors, as well as representatives from LHINs, community health centres, hospitals and government. Its purpose was to recognize the importance of the province's funded psychotherapy initiative and bring providers together to discuss the next steps forward.

The morning's presenters established the context of the psychotherapy discussion to follow and helped to clarify some of the important progress government has made so far.

MENTAL HEALTH AND ADDICTIONS LEADERSHIP ADVISORY COUNCIL

The first presenter offered some history on the issue. Gail Czukar, a member of the provincial Mental Health and Addictions Leadership Advisory Council, explained how the move to expand access to psychotherapy programs is a response to recommendations made by the council's second annual report, *Moving Forward: Better Mental Health Means Better Health*. The presentation mapped a path from the province's achievements – such as improving collaboration between ministries to support youth mental health and making efforts to address social factors like supportive housing for people with mental health and addiction issues – and to the council's recommendations. Among these was a specific call to create a pilot project focused on identifying the most effective means of scaling up access to structured psychotherapy.

HEALTH QUALITY ONTARIO

The subsequent presentation from Health Quality Ontario's Erik Hellsten offered some perspective on how the delivery of structured psychotherapy fits within the broader set of evidence-based treatments recommended in Health Quality Ontario's quality standards for mental health-related conditions. The presentation examined how quality standards are created, how they will be measured, and how psychotherapy plays an important role in the quality standards for Major Depression and Schizophrenia.

MINISTRY OF HEALTH AND LONG-TERM CARE

The last presentation of the morning outlined the Ministry of Health and Long-Term Care's three-phase approach to shifting more importantly into mental health and addictions, and how psychotherapy fits into this move. Investments in structured psychotherapy, explained the director of mental health and addictions branch, Patrick Mitchell, should be seen as a down payment on what will ultimately be a transformed system. As the pilot program for structured psychotherapy rolls out under the coordination of four speciality mental health hospitals, the province hopes to begin developing a wider program model with the help of an advisory panel comprised of people working in the field of mental health as well as people with lived experience. A key learning from this initial phase, he explained, will be to understand what kind of demand will be generated for this service and how we can use existing programs and evidence-based modalities to better serve Ontarians.

CHALLENGES

The roundtable's working session began by identifying some of the system's current challenges as well as some of the challenges inherent in scaling up structured psychotherapy as a service.

The discussion touched upon a number of points, including:

Timeframe for services don't line up with funder expectations. Expectations of different funders can be misaligned so that by meeting the goals of one we have missed the goals of another. "For example, to meet the standards for treating depression we would have to change our length of service, which would mean we would serve fewer people," said a participant. To be successful, we need to have conversations about aligning all the different requirements.

People with anxiety and depression don't just come in through MOHLTC. People with mental illness will access services through many different government doors, from the Attorney General and Legal Aid, Ministry of Community and Social Services (inmates in corrections facilities), Ministry of Labour (occupational health issues of first responders), Ministry of Finance (brain injuries through auto insurance), Workers Safety Insurance Board (workplace injuries), Ministry of Housing (social services). "People don't access services and the system the way we think. How do we bridge between where the care happens and where it needs to happen?" asked one participant. It's important to have mechanisms that enable service providers to connect.

Coordination between public and private services. What are the relationships that the public services have with other services out there? How do we ensure that a new program of structured psychotherapy aligns with the system and providers who are currently offering similar treatments?

Barriers to engagement. Some patients are very resistant to the notion of being treated for mental illness. More specifically, some cultures might not want to engage with psychotherapy. One participant suggested examining the further integration of a personalized advantage index (PAI) to understand what might best work for each patient. Unengaged patients may simply not understand what service they have been referred to. One participant suggested that half the patients sent from primary care to the team's social workers had no idea they were there for psychotherapy. Patients need to be a part of the decisions and processes of transfer from one service to the next.

Not a unidirectional journey. Patients with mental illness move back and forth between levels of acuity. Hand-offs or shared care needs to be coordinated between providers with the understanding that patients may step up or down in the intensity of their care. Triage, said one participant, isn't just something that is done at the front end, it should be part of a complete model of care. On this note, one participant expressed caution over the use of the term 'triage', which could mean: Who can we exclude from the service. "It's about which part of care you get, not whether you get care or not. You should be able to get just the right amount of care."

Pathways for communication. Social workers, psychologists and other mental health providers sometimes need to connect with primary care physicians about patients but that channel is not easy to navigate. Without the ability to coordinate care some advantages and efficiencies can be lost. We need ways to enhance communication – so that providers inside and outside of health can contact one another if care is not progressing as needed.

System not designed for universal access. Some people don't have access to technology, or don't have the financial means to access technology, so when creating online services, it's important to consider this demographic. We also need to apply an anti-racism and anti-oppression lens as we design a system of access to psychotherapy. We must remember that psychotherapy comes from a western cultural frame, said one participant, adding that she was told by a member of a First Nations that psychotherapy is not going to work. The delivery of psychotherapy services and the standard for delivering them should be mindful of these different communities. We will need flexibility in the standards to accommodate these differences.

Inter-ministerial information not shared. Gathering data on patients and system users is critical to transformation, but data doesn't flow easily between ministries or centres of responsibility. One participant explained that an inmate leaving a correctional facility does not have access to their health information during their period of incarceration, for example. "If you asked that person what mental health services they received while in custody, they would likely not be able to tell you. And there would be no way for the primary care provider to find out." There should be single database that connects a person as they contact various government agencies.

We do not teach enough mental health system literacy. We need to develop better mental health literacy for every service that connects to people with mental illness. This will create a wider understanding of not only what services are available but how these services function. The target audience should reach beyond the system providers to include families and system users.

Providers of psychotherapy are geographically concentrated. As is the case with many health care professionals, psychiatrists and psychologists are more highly concentrated in urban areas compared to rural areas.[9] Rural areas also tend to have a higher proportion of health care professionals – including psychiatrists – heading into retirement, with relatively few mid-career professionals practicing in rural areas.[10] The trend towards an urban market saturated with psychotherapy providers and lack of accessibility in rural areas must be considered when developing a strategy for the provision of structured psychotherapy. Making treatment accessible digitally, through tele-health and e-health services, can also help overcome geographic barriers and provide outreach to underserved communities.

Increasing access to structured psychotherapy across the lifespan. Investing in timely, developmentally appropriate resources for children and youth with mental health difficulties is crucial to ensuring that they go on to lead productive, healthy lives. The delivery of publicly-funded psychotherapy should eventually plan to include services for youth and children and include tailored strategies to address the complexities associated with serving this population.

9 http://www.cpa.ca/documents/geographic_survey.html
10 http://pubmedcentralcanada.ca/pmcc/articles/PMC5302108/

RECOMMENDATIONS

With a number of challenges and proposed solutions outlined, the group committed a final discussion to identifying areas that would benefit from further exploration.

Alongside each recommended area for exploration is an international example of best-practice work being conducted globally. This case study method was used to exemplify how some of the recommendations from the roundtable can be put into practice.

Four specific categories of recommendations emerged:

1 SKILLS. CHANGE MENTAL HEALTH CARE TRAINING AND EDUCATION

A large portion of the workforce engaged in the delivery of mental health is skilled in managing acute behaviours and persons in crisis. Addressing the needs of a population with mild to moderate mental health issues will require a thorough assessment of our current training and services to ensure they best serve these patients. For example, providers trained to deliver individual therapy, including psychologists, social workers and psychotherapists, may need to acquire new skills to deliver group therapy where a deeper understanding of group composition and pre-group preparation can ensure greater success.

Mental health training should also feature more prominently in the training of physicians, occupational therapists, care coordinators, social workers and case workers. A curriculum should be designed to understand and evaluate mild to moderate anxiety and depression that will ensure a clear and consistent course of action is taken. We must also build capacity system-wide to understand and deliver structured psychotherapy that are in consensus guidelines, from cognitive behavioural therapy and interpersonal psychotherapy (IPT) to motivational interviewing (MI).

RECOMMENDATIONS FOR IMPROVING SKILLS CAPACITY:

- **Develop a comprehensive training program and evaluation process** for long-term planning and re-training based on different levels. Consider how these orgnaizations can be supported for their training and skill building efforts. Regular supervision is necessary initially to guarantee fidelity to the psychotherapy modalities.
- **Scale up the provision of evidence-based psychotherapies** like CBT, IPT, MI and other evidence-based treatments and interventions.
- **Leverage coaching** and mentoring programs such as the Ontario College of Family Practice's collaborative mentoring networks.
- **Create a mental health human resources plan** that outlines what kind of capacity we need in our workforce, by when and for what patient types.

IMPROVING RESOURCE UTILIZATION: CLOSING THE TREATMENT GAP THROUGH TASK-SHARING ACTIVITIES.

In Ghana, only two in every 100 people suffering from mental health problems will receive the help they need, in part due to resource limitations and an uneven distribution of services across urban and rural areas.

The Kintampo Project aimed to respond to the mental health treatment gap in rural Ghana by training a new community mental health workforce of community mental health officers and clinical psychiatric officers. These professionals are trained in regional 'hub and spoke' centres, and contribute to the healthcare system by offloading tasks that would otherwise be fulfilled by the scarce psychiatric workforce.

Community mental health officers receive one year of training, and aim to detect mental illness, provide support to patients and their families, and build culturally-specific treatment and support for mental health issues. In contrast, clinical psychiatric officers receive two years of training and are trained to diagnose mental illness and prescribe medication, supervised by psychiatrists.

Early results from The Kintampo Project have demonstrated great success[11]: increasing the workforce capacity through task-sharing has resulted in a **200% increase** in the number of people treated for mental illness in Ghana. The trained community mental health workforce has increased by 96%, and the medical psychiatric workforce by 89%. Importantly, through delegating care activities to these new providers, psychiatrists' expertise can be utilized to care for acutely ill patients.

11 http://www.mhinnovation.net/innovations/kintampo-project

2 COMMUNICATION. CHANGE HOW CARE PROVIDERS SHARE INFORMATION AND COORDINATE CARE

Health care providers may be aware of the mental health services available to their patients in their region, but do they know what service to refer to based on a patient's needs? This decision should involve several levels of consideration, including what intensity of care the patient requires, and what care provider could best fulfill those requirements.

A triage-based system across care providers would see patients being assessed as they move from provider to provider. This will ensure that a patient's constantly changing care needs are not only coordinated between services but also better communicated. This improved communication between health care providers will also mitigate the negative patient outcomes associated with inappropriate referrals. Alongside the development of a triage-based system is the need to develop a clear and universally-accepted definition of what constitutes a mild anxiety or depressive disorder and what is considered moderate. It is also important for patients to be educated about their referral and for measures to be in place to aid them in their transition between care providers.

RECOMMENDATIONS FOR IMPROVING COMMUNICATIONS BETWEEN PROVIDERS:

- **Create a province-wide mental health asset map** that shows what services are provided where.
- **Develop a clear and universally-accepted definition** of what constitutes mild anxiety or depression and what is considered moderate.
- **Increase smarter, better coordinated reliance on private services** to fill gaps in public services.
- **Case management role** to assist in care coordination and navigation beyond simply the health care sector – collaborate with patient, not for patient.
- **Integration of outcome monitoring** with clinical practice to provide feedback to health care providers.
- **Include primary care** to help refer, be involved with care coordination.
- **Consider better linkages for patients** in cognitive behavioural therapy with addiction co-morbidity. Connect them to addiction resources and with skilled practitioners.
- **Consider acuity in some conditions** and how a schizophrenia patient, for example, must fit into the system at different stages – including recovery.
- **Leverage Canada Health Infoway's interest** in a shared referral system. A regional intake program ("one-stop shop") may improve efficiencies and help with wait times.

A CASE FOR COMMUNICATION: INNOVATING YOUTH MENTAL HEALTH CARE IN AUSTRALIA.

Australia is home to numerous leading innovative mental health initiatives, among which includes ***headspace***, a youth mental health program established by the Australian government in 2006. *headspace* provides early intervention mental health services, including structured psychotherapy, to youth aged 12-25 with the goal to reduce the burden of untreated mental illness in later life. The services are low-cost – and often free – for its users. Since its inception, *headspace* has provided over 1.5 million services to 255,000 youth across urban and rural areas of Australia.

headspace utilizes a 'hub and spoke' model for mental health care, employing a team of primary care physicians, psychologists, psychiatrists, social workers, and mental health nurses to serve patients' needs in a central location. Care providers across varying levels of specialization administer structured psychotherapy, including cognitive behavioural therapy.

At their first appointment, patients meet with a youth access clinician, who consults with the patient about their concerns, and then hands off the patient to the medical professional that best suits their needs. The patient's youth access clinician acts as the patient coordinator throughout their time at *headspace*, monitoring the patient's progress and reassigning the patient to higher or lower levels of care if necessary.

By building rapport with patients and facilitating handoff between care providers, the youth access clinician ensures that patients' care needs are clearly communicated, and patients can access care that is appropriate given their symptom severity. In turn, this **increases care providers' clarity on both the patient's needs and their role within their care delivery, leading to better care outcomes.**

3 MONITORING CHANGE HOW WE MONITOR CARE DELIVERY

Measurement-based care is a core element of evidence-based treatment. It provides insight into treatment progress and symptom progression through patient self-reporting and clinical practice guidelines. By measuring care throughout the patient journey, providers can assess patient progress over time, develop greater patient-provider understanding, and ensure that the patient's treatment is informed by the patient's individual experience with his condition.

Measurement-based care is used routinely on the medical side but less widely in psychiatric care. The adoption of evidence-based skills to evaluate a patient's experience with psychotherapy is well overdue. Care providers must be encouraged and enabled to use these metrics in clinical practice. Collecting this information will serve to inform programming activities, such as determining which evidence-based psychotherapy interventions work best in what situation. Furthermore, ongoing monitoring of a patient's response to treatment can help to determine that person's optimal treatment pathway.

RECOMMENDATIONS FOR IMPROVING MONITORING:

- **Use metrics** from both public and private system. Well validated clinical scales should be used to monitor outcomes of the psychotherapy treatment.
- **Build accountability frameworks** that commit people to performance plans and outcomes.
- **Focus on health outcomes** for patients and not volumes (e.g. number of patients seen).
- **Ensure continuity of patient care** by establishing open and adaptive communication between the psychotherapy provider and other providers in a patient's circle of care.

A TEAM-BASED APPROACH: WORKING TOGETHER TO ACHIEVE BETTER PATIENT OUTCOMES.

In a system where accessibility of care is such a large issue, it is important to ensure that emphasis is also placed on assessing a patient's experience in psychotherapy to ensure that they are benefiting fully from their treatment. **Collaborative Care**, a program created by the University of Washington, integrates clinical teams and regular monitoring to achieve positive outcomes for individuals with a mental illness.

The program is delivered in family care facilities by teams comprised of a primary care provider, a care manager (a nurse, social worker, or psychologist), and a remote psychiatric consultant. These teams provide comprehensive care to a group of patients with a common mental health condition such as clinical depression or anxiety, with the care manager being the primary contact for the patient. **Each team member's role is well defined and their role within the team remains consistent across all patients, making it easier for the members to understand their responsibilities.**

Notably, within these teams, the primary care provider – rather than the psychiatrist – carries out front-line treatment for the patient, and the care manager provides medication management and brief psychotherapy. The psychiatrist advises the primary care provider on the suggested method of treatment, enabling the primary care provider to deliver comprehensive treatment to their patient, with the monitoring and management of the care manager.

Monitoring patient progress within their treatment is an integral element of the program, and care managers take an active role in measuring patient success in their treatment method. Patients' progress is monitored at each meeting with their care manager using validated clinical rating skills, and the care manager facilitates communication between the members of the team to ensure that all members are aligned on a patient's progress.

This patient-centered approach is designed to increase patient success in their method of treatment, and increase the role of primary care providers, nurses, social workers, and psychologists in mental health care. The results of this demonstrate great success: **up to $6 can be saved in long-term health care costs for each $1 spent in collaborative care.**[12]

12 http://aims.uw.edu/collaborative-care/building-business-case-cost-effectiveness-studies-collaborative-care

4 DELIVERY CHANGE HOW WE TRIAGE PATIENTS

Currently, patients seeking treatment for mental illness report fragmented care experiences often fraught with inconsistencies between care providers and an overall lack of communication. Many of the inconsistencies they may have experienced arise from a lack of understanding over the role of one care provider or another. A lack of coordination can be particularly detrimental when caring for patients with comorbid disorders or severe conditions, where specialists from various disciplines provide treatment at different care points throughout the patient journey.

Good care delivery begins with a good start. Patients should be assessed using a common understanding of their level of symptom severity and introduced to treatment using a stepped care approach, where possible under a collaborative care model. Rather than being placed in intensive treatment to begin, which both may not be necessary for the patient and places strain on complex resources, patients should be placed from the beginning in the correct level of treatment. The intensity of the treatment will vary according to their constantly changing needs. Implementing culturally-sensitive, through tele-health and e-health initiatives, evidence-based treatment will also become increasingly necessary as not all patients respond to western-based psychiatric therapies.

RECOMMENDATIONS FOR IMPROVING DELIVERY:

- **Scaling up a collaborative care model** with training focused across all care providers.
- **Build accountability frameworks** that commit people to performance plans and outcomes.
- **Implement culturally-sensitive, preference-based practices** into care delivery.
- **Focus on evidence-based models of delivery**, including group models of care.
- **Supervision of all therapy** across levels of care.

A BETTER SYSTEM OF CARE:
HIGH QUALITY MENTAL HEALTH CARE MEETS FAMILY MEDICINE.

Some family health teams in Ontario have managed to build integrated practices that include a staff of mental health counsellors working with a core team of psychiatrists - all of whom support the primary care providers. The **Hamilton Family Health** team is a leader in this model of shared mental health care.

There are a few such programs throughout the province but Hamilton has the highest number of family practices involved. Operating with this model of care since 1994, it has now grown to include 170 family physicians and almost 300 other health care workers.

Structured psychotherapy is part of the services offered. It's delivered by nurses and social workers who are supported with ongoing education and supervision from psychiatrists.

Depending on a family practice's needs, a psychiatrist will spend a day or half a day a week in a primary care centre as a mental health resource. The psychiatrist is involved in direct care as well as indirect care such as discussing cases, identifying community resources, providing system navigation, supporting plenary care providers and teaching.

"It's not just sitting in an office at the end of the corridor," says Dr. Nick Kates [Former Director of Programs, Hamilton Family Health Team]. "We're part of the practice. We mix with everyone in the practice and it gives us all the opportunity for informal case discussion, updates and answering quick questions."

The psychiatrist serves primarily as a consultant while the counsellor tends to be directly involved in the delivery of psychotherapy. Dr. Kates says on average team psychiatrists see a patient twice although 50% are only seen once and a number are seen more frequently to complete the initial assessment, to stabilise the symptoms and to review the plan before care is hand back to the family physician or mental health counsellor, with the psychiatrist being able to get re-involved at any time.

"It's very much a shared model of care. I may see someone in consult and hand back to a physician but if something is not working they know they can hand the patient back."

The family physician remains the key point of contact for continuity of care and is typically the first point of contact for mental health issues, but referrals come from the counsellor, pharmacist, and dietitian, anyone in the FHT.

While family health teams are exemplary models of primary care, not everyone works with, or has access to, an FHT. While being in the same office is important, services must also function together. That's why it's important to redesign the system of care to take advantage of the resources you have, whether you work in a family health team or not. Family physicians, for example, should make themselves available to meet regularly with the counsellors. In Hamilton, they found that just **15 minutes a week is all that is required to maintain regular contact and keep team members up to date.**

The shared mental health care FHT concept is designed to integrate mental health services within primary care into mental health in a well organized way, says Kates, so that the patient journey can begin and end in their Medical Home.

HERE ARE 5 THINGS HAMILTON FHT LEARNED SHOULD BE IN PLACE FOR SHARED MENTAL HEALTH CARE TO FUNCTION WELL:

1. **Perform face-to-face reports and handovers of care**
2. **Provide clarity about each person's role (and reasonable expectations for staff who are only there a few days a week)**
3. **Ensure there is organizational support**
4. **Identify a family physician champion**
5. **Everybody charts in the same medical record**

CONCLUSION

Progress is being made and it's important to maintain not only the momentum, but to head in the right direction. Ontario Psychiatrists and its roundtable working group hope to see further involvement in the development of Ontario's structured psychotherapy program.

Moving forward, we would encourage government and stakeholders to consider the following two guiding principles:

> **These providers are engaged and invested. Use them.** The high rate of participation in this roundtable discussion from all levels of mental health care providers indicates an important level of engagement from this group, which has shown to be collaborative and motivated. Government would be encouraged to leverage the enthusiasm, knowledge and dedication of these participating organizations as it forms committees, working groups and advisory panels.

> **Not everyone needs to see a psychiatrist.** Patients need to find the right provider to provide the right type and level of care at the right time. This will enable our health care system improve expected outcomes for treatment and to make better use of all the other providers in mental health, such as the psychologists, social workers, occupational therapists, mental health nurses and primary care physicians. Initiatives in this area should focus on improving the coordination mechanism between these care providers.

ATTENDEES TO THE COALITION OF ONTARIO PSYCHIATRISTS' PSYCHOTHERAPHY ROUNDTABLE HELD ON JUNE 28TH, 2017, IN TORONTO INCLUDED:

Disclaimer: participation in this roundtable does not equate to endorsement of all recommendations in this report by any participant or affiliated organization.

Christina Bartha, SickKids

Lawrence Blake, Canadian Mental Health Association, Ontario Division

Susan Clancy, Queen West Community Health Centre (Toronto)

Gail Czukar, Addictions and Mental Health Ontario (AMHO)

Dr. Jeff Daskalakis, CAMH

Erik Hellsten, Health Quality Ontario

Sophie Hwang, Schizophrenia Society of Ontario

Jan Kasperski, Ontario Psychological Association

Joan MacKenzie Davies, Ontario Association of Social Workers

Dr. Ross Male, Ontario Medical Asssociation (Section of General and Family Practice)

Dr. Ian Manion, The Royal

Steve Mathew, Ontario Telemedicine Network (OTN)

Robin McAndrew, Sandy Hill Community Health Centre (Ottawa)

Dr. Brian McDermid, Medical Psychotherapy Association Canada (MDPAC)

Rob McKay, Ministry of Health and Long-Term Care (Mental Health and Addictions Branch)

Dr. Susan McNair, McMaster University

Dr. Deanna Mercer, The Ottawa Hospital

Patrick Mitchell, Ministry of Health and Long-Term Care (Mental Health and Addictions Branch)

Robert Moore, CAMH

Alicia Raimundo, Lived Experience Advisor

Dr. Sanjay Rao, The Royal

Dr. Paula Ravitz, University of Toronto and Mt. Sinai Hospital

Alyson Rowe, Office of Dr. Eric Hoskins (Minister of Health and Long-Term Care)

Dr. Sylvian Roy, Ontario Psychological Association

Antonella Scali, Schizophrenia Society of Ontario

Dr. Kathy Short, School Mental Health ASSIST

Nancy Sikich, Health Quality Ontario

Adrienne Spafford, Office of the Premier

Dr. Giorgio Tasca, University of Ottawa

Alicia Tough, Ontario Society of Occupational Therapists

Victoria Williams, Toronto Central LHIN

Facilitated and moderated by:

Yvan Marston, Santis Health

Patrick Nelson, Santis Health

Jessica Stepic, Santis Health

Ross Wallace, Santis Health

Victoria Wiebe, Santis Health

Attendees from the Coalition of Ontario Psychiatrists:

Dr. Desi Brownstone

Dr. Gary Chamowitz

Dr. Mathieu Dufour

Dr. Tom Hastings

Dr. Sarah Jarmain

About THE COALITION OF ONTARIO PSYCHIATRISTS:

The Coalition of Ontario Psychiatrists is a formal partnership of the Ontario Psychiatric Association and the Section on Psychiatry of the Ontario Medical Association, and was formed in the late 1990s to facilitate coordination and cooperation between these two associations. It represents over 1,900 psychiatrists who provide high quality mental health services for Ontarians.